Northern Michigan Regional Diabetes Initiative Project Logic Model: 10 Year Plan

Individual, Community, and Staffing and **Planned Activities Expected Outcomes: System Conditions Phases** Year Ten 1.1 Scope and Prevalence: Eleven 2.1 3.1a Steering Committee will be responsible for project oversight, fiscal After successful project management, on-going evaluation and procurement of new funds implementation, Michigan's (11) county region in northern Staffing Michigan. Over 16,000 with for sustainability. northern region will experience 3.1b Project Coordinator will be responsible for implementing work plan the following: diabetes. Estimated 40% of the in collaboration with partners (including in-kind staff). Quarterly adult population has pre-diabetes. progress reports to fund sources and Stakeholder Committee. Community-at-Large: Close to 7,000 who have diabetes, but are unaware of it. • Increase number of persons screened for 3.2a. Train on New Practice Standards. Through face-to-face office visits. **1.2 Practice Standards**: For diabetes diabetes. and educational forums, 200 region-based physicians, health care diagnosis and management in 2.2 providers and educators will be trained on the Chronic Care model Increase number of primary care, the standards of care & best practice standards for screening, diagnosis, and treatment. Year One persons diagnosed with are being used in various degrees, 3.2b. Expand Self-Mgmt Program Capacity. Two (2) new region-based pre-diabetes or diabetes. with many falling short of national coalition members will complete evidence-based Stanford Chronic Self Management Disease (P ATH in Michigan) Master training. 2-3 practice standards. Persons with Pre-Diabetes new PATH programs will be completed · Delay the onset of 3.2c. Implement Region-specific Awareness Campaign. Target key sub-1.3 Evidence-based Selfdiabetes. population groups include parents of school-aged children, undermanagement Programs: Current insured/uninsured, people with diabetes and age group most at risk • Increase number of regional Diabetes Self-Management for diabetes. Conduct phone surveys and focus groups to assess persons achieving target Programs are underutilized. diabetes-related awareness. Design/test draft messages. health measures Programs to teach patients to take Produce/implement region specific multi-media campaign. an active part in their health are not 3.2d Advance Data Management Systems. Link medical record and lab Persons with Diabetes currently meeting need. Existing results for people with diabetes. Assist practices with data tracking local health plan data indicates that · Increase number of and monitoring of patients. less than 40% of patients with persons achieving target diabetes are achieving good control health measures (from 3.3a. Evaluate results, lessons learned and make improvements. of their disease. 35% of patients to 50%) 3.3b. Train on New Practice Standards. Continue to stay current on new Increased number evidence-based practices and train 200 region-based physicians, 1.4 Prevention Activities: Current receiving all recommended 2.3 health care providers, and educators each year. prevention activities are insufficient. 3.3c. Expand Self-Mgmt Program Capacity. Four (4) new PATH programs annual tests **Years Two** not accessible to those at greatest will be completed. Aggregate reports to track increased self · Delay the onset of and Three risk, and not coordinated across the management skills within the region will be generated. complications related to region. 3.3d. Produce Multi-media Campaign spots and implement media diabetes condition. · Decrease number of lower 1.5 Collaborative: Community-based 3.3e. Promote and Expand Self-Management Programs and healthy partners (including Munson extremity amputations lifestyle programs in the community for all ages. Healthcare, Priority Health, · Decrease days of TIPDON, and other regional hospitalizations due to 3.4a. Evaluate results and lessons learned and make improvements stakeholders) actively participate in diabetes-related condition. 3.4b. New Practice Standards and Program Models. Continue to stay a 50-member stakeholder 2.4 current on new evidence-based practices and provide updates to committee to provide direction and health care providers, and educators each year. **Years Four** other in-kind resources. Funding 3.4c. Promote Healthy Lifestyle Programs in the community for all ages. thru Ten has been committed for one-year with continuation after review.